# SMMGP News and Updates

SMMGP news and updates for members, including Policy and Clinical updates.

## SMMGP Clinical Update

SMMGP Clinical Update is compiled by Euan Lawson. This issue includes

- Abuse potential of pregabalin: a systematic review.
- ACMD advice - pregabalin and gabapentin.
- Reasons for missed appointments with a hepatitis C outreach clinic: a qualitative study.
- The effectiveness of compulsory drug treatment: A systematic review.
- Investigating the role of benzodiazepines in drug-related mortality

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**Abuse potential of pregabalin: a systematic review.** *Schjerning O, Rosenzweig M, Pottegård A, Damkier P, Nielsen J. CNS Drugs 2016, Jan;30(1):9-25.*

This systematic review included 17 pre-clinical, 19 clinical, and 13 epidemiological studies. They also reviewed nine case reports. Overall, they found that there were certainly indications in the pre-clinical studies, given pregabalin's effects on the GABA and glutamate systems, of potential for abuse. This was borne out in the clinical studies that have shown that euphoria was a frequent side effect, usually found in 1-10% of patients. In one study it was as high as 26% and the pharmacodynamics of pregabalin, compared to gabapentin, make it more potent. The case reports mostly involved patients who had a history of substance misuse and the epidemiological studies confirmed evidence of abuse particularly among opiate users.

**ACMD advice - pregabalin and gabapentin.** *Advisory Council on the Misuse of Drugs (2016). London: Home Office. Available at https://www.gov.uk/government/publications/advice-on-the-anticonvulsant-drugs-pregabalin-and-gabapentin*

The ACMD reported to the Minister for Preventing Abuse and Exploitation, Karen Bradley MP, on pregabalin and gabapentin. The ACMD completed a review of the potential harms associated with misuse. They noted that pregabalin and gabapentin prescribing has increased by 350% and 150% respectively in the past five years. Northern Ireland has seen a significantly higher rise in use. Ultimately they recommend a change in the law: pregabalin and gabapentin to be controlled as Class C substances and scheduled as Schedule 3.

**Commentary:** The academic papers are perhaps rather late to this particular party and anyone with a passing involvement in clinical practice will have little doubt about the abuse potential of pregabalin. However, it is interesting to read this systematic review which sets out in the clearest of terms and with detailed reference to the underpinning pharmacology. It was also noted in the review that there may be a potentiating effect with other psychotropic drugs which could be important - if just 1% of users got a euphoric effect it seems less likely to have become a problem. Parenthetically, it is worth noting that despite explorations, there is no clear role for the use of pregabalin in treatment of addiction disorders. We are exhorted to exercise “caution” in prescribing. I think most of us are cautious with any prescribing and no one is suggesting a blanket ban for these medications. For all the challenges, pregabalin and gabapentin remain licensed and NICE recommended treatments for several conditions that have strong associations with substance misuse disorders.

**Reasons for missed appointments with a hepatitis C outreach clinic: a qualitative study.** *Poll R, Allmark P, Tod AM. International Journal of Drug Policy 2016, Feb. Available online at http://www.ijdp.org/article/S0955-3959(16)30017-2/abstract*

This UK study managed to contact people who had a history of not attending the hepatitis C outreach clinic. They were all given a telephone interview and participants were remunerated with a high street voucher to the value of £5. In total, they conducted 28 telephone interviews and all the clients offered some reason, described as "prima facie" by the researchers, for not attending. However, the authors felt that these reasons were not sufficient to explain the non-attendance and the other underlying reasons were explored as part of the study. While the excuses often seemed apparently quite simple - such as clients basically forgetting appointments in the turmoil of chaotic lifestyles, the underlying reasons were often far more complex.

**Commentary:** An important topic this one and it is good to read something with a wee bit more weight to it than my idle speculation on the reasons for DNAs. Yes, we often accept, at face value, the assertion that someone didn't attend because of a 'chaotic lifestyle' but it is unsatisfactory and unhelpful when it comes to addressing the problems. We can over-simplify the problem of non-attendance and the authors are at pains to point this out. The common excuse of simply "forgetting" is too easy to accept and is described as hazardous by the authors. The fact is that complex interventions, such as peers and peer mentors, will be needed to address these kind of challenges and it is not sufficient to sit back and wait for better treatments for hepatitis C to resolve any ongoing problem. The authors also noted that there is continuing evidence of structural factors within hospitals that promote stigmatisation of drug users with hepatitis C. The various factors that were experienced by the participants were often quite variable and they "played out in different ways in different combinations by different people". Which is, unintentionally, a wonderfully accurate description of clinical practice.

**The effectiveness of compulsory drug treatment: A systematic review.** *Werb D, Kamarulzaman A, Meacham MC, Rafful C, Fischer B, Strathdee SA, Wood E. Int J Drug Policy 2016, Feb;28:1-9.*

They found nine quantitative studies that met the inclusion criteria. These covered a range of compulsory treatment options including drug detention facilities, short and long-term inpatient treatment, community-based treatment, group-based outpatient treatment, and prison-based treatment. One third of the studies reported no significant impacts compared with control; two studies were equivocal but didn't have a control group; a further two studies observed a negative impact on criminal recidivism; and, lastly, two studies observed positive impacts of compulsory inpatient treatment on criminal recidivism and drug use.

**Commentary:** Overall, there is limited evidence on the evaluation of compulsory drug treatment. The evidence does not seem to suggest improved outcomes as it stands and there are certainly some potential harms. Personally, I'm queasy about any compulsory treatment requirements – whether it is a requirement to get into treatment, or whether it's a requirement to reduce opiate substitution therapy or go through detox, it all leaves me deeply uneasy. Given the moral and ethical concerns, with potential for human rights abuses with compulsory drug treatment settings, the evidence of benefit would have to be very strong to outweigh the potential downsides. That certainly doesn't seem to be the case.

**Investigating the role of benzodiazepines in drug-related mortality.** *Johnson, Barnsdale and McAuley A. (2016).Public Health Information for Scotland. Available at* *http://www.scotpho.org.uk/publications/reports-and-papers/1803-investigating-the-role-of-benzodiazepines-in-drug-related-mortality*

This is a detailed report from Public Health Information for Scotland written after the role of benzodiazepines was identified as a priority area by the Scottish National Forum on drug-related deaths (DRDs). It comprised of a systematic integrative literature review and databases were searched from 1970 up until March 2015. It was noted that the widespread use of benzodiazepines from licit and illicit sources has made it difficult to legislate in order to restrict access. However, it noted that the diversion of prescriptions has reduced over the past 20 years but the emergence of different benzodiazepine type drugs and novel psychoactive substances has added to the complexity of the picture.

The adverse effects of benzodiazepines were described: sedation, dependence, and cognitive impairment. Certainly cognitive impairment may be a factor in drug-related deaths as it could increase risk taking behaviour and reduce harm reduction advice. There are also some paradoxical effects and pro-arrhythmic effects which could play an important role as well. The paradoxical effects are typically disinhibitory with effects such as impulsiveness and aggression – with between 1% and 20% of those taking prescribed normal doses affected. It has been shown that even at normal doses diazepam and other benzos can have a pro-arrhythmic effect in susceptible people. These adverse effects have also rarely been reported with z-drugs such as zopiclone and zolpidem. Given the much larger doses taken when benzos are misused this may be a significant factor in DRDs as well. The pro-arrhythmic effects include QTc prolongation and clearly the combination of this and drugs such as methadone and tricyclic antidepressants, as well as pre-existing cardiovascular disease and electrolyte imbalances associated with liver disease, all can add up to a potentially lethal combination.

**Commentary:** This report highlights the complexity of this issue: the host of different factors involved; the lack of information about so-called “megadoses” and the “benzo-burden”; variations in drug blood concentrations; and the wide variety of emerging drugs with similar effects. It’s obvious that benzodiazepines are important but, it is also clear that there is a marked lack of understanding on how exactly they are implicated. The pro-arrhythmic effects of high dose benzos are covered in some detail here and will be useful to clinicians to bear in mind.

Interestingly, and completely unexpectedly, there also seems to be some evidence that naloxone can reverse benzodiazepine and z-drug effects. There are different theories about why this might be the case but clearly it would be an important area for research. It also highlights the importance of widespread and easy access to naloxone in the case of overdose – it would be a huge bonus if naloxone also proves to be potentially life-saving in cases of benzodiazepine overdose. However, it is also noted that the disinhibitory effects of benzodiazepine intoxication may be a factor in reducing users willingness to seek help and use naloxone.

**Which medications are suitable for agonist drug maintenance?** *Darke S, Farrell M. Addiction 2015, Oct 27.*

This short paper is offered up for debate in the pages of Addiction. They explored the feasibility of agonist maintenance treatment for the major psychoactive drugs: opioids, nicotine, benzodiazepines, cannabis, psychostimulants and alcohol. They applied eight clinical criteria for an agonist maintenance drug relating to pharmacological aspects (agonist, pharmacological stability, dose-response, non-toxic) as well as neurocognitive sequelae (psychiatric, cognitive, craving, salience).

They found that opioids and nicotine met all eight criteria for a maintenance drug. Cannabis met five of the criteria and has some potential but there was concern about the long-term data on cognitive impairment. The paper also suggested that benzodiazepine maintenance could be an option for the high-dose chaotic user, as it met five criteria, but they suggested that clinic dosing would be the safest option. Psychostimulants met just three of the eight criteria and alcohol met just one of the eight criteria.

**Commentary:** This is a common enough question in the clinic. If I can have methadone and buprenorphine prescribed for opioid dependence, why can't I have benzos prescribed? (Interestingly, heroin didn't score as highly as synthetic long-acting medications such as methadone and buprenorphine.) Nicotine is shown to be a very strong candidate and given the harm related to smoking it should be strongly considered. Benzodiazepines are a more complex picture, as the authors readily admit, but the paper suggests that there could be a theoretical role for maintenance benzos in the "high-dose chaotic user". However, given a likely need for clinic dosing this would be require a lot of resource and, in cash-strapped services, it would take a lot more evidence than this debate paper to justify implementing this in practice.

## SMMGP Policy Update

**Mixing Drink and Drugs: "Underclass" politics, the Recovery Agenda and the Partial Convergence of English Alcohol and Drugs Policy**
*M Monaghan, H. Yeomans Feb 2016* http://www.ijdp.org/article/S0955-3959(16)30013-5/abstract
(Athens access is needed to read the full article, the abstract is summarised below):

Whilst criminal law upholds a "great divide" separating the licit trade in alcohol from the illicit trade in substances classified as either class A, B or C under the *Misuse of Drugs Act 1971*, explicit comparisons are made in this article of recent policy developments used to govern alcohol and illicit drugs in England.

In the article, consideration is given to the idea of a convergence between policies governing alcohol and illicit drugs in England, through the lens of the "recovery agenda". In doing this, it draws upon Berridge's (2013) argument that policies governing various psychoactive substances have been converging since the mid-twentieth century and seeks to elaborate it in relation to the control and regulation of drugs and alcohol in the broader areas of criminal justice and welfare reform.

Significantly, the article examines how recent policy directions relating to both drugs and alcohol in England have, under the auspices of the 'recovery agenda', been connected to a broader behavioural politics oriented towards the actions and lifestyles of an apparently problematic subgroup of the population or 'underclass'. The paper thus concludes that, although the great regulatory divide remains intact, an underclass politics is contributing

towards the greater alignment of illicit drugs and alcohol policies, especially in regards to the respective significance of abstinence (or abstinence-based 'recovery').

**Commentary**: This article provides an interesting angle on the influence of the "recovery agenda" in recent years and the significance of becoming abstinent being viewed as a way of addressing the actions and lifestyles of an "underclass" of people who misuse drugs and alcohol.

## SMMGP News

RCGP Royal College of General Practitioners

SMMGP

### 21st Managing Drug & Alcohol Problems in Primary Care Conference

**SAVE THE DATE**

**Friday 4 November 2016**
**RCGP, 30 Euston Square, London**

The conference will look at:

- what's new and relevant in the drug and alcohol field
- the latest on Hepatitis C
- drug-related deaths
- end of life care
- novel psychoactives
- addictions to medicines.

**Further details will be available soon on the RCGP website.**

In the meantime save the date and look out for registration details shortly.

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**Public Health England Capital Fund – SMMGP awarded funding**

SMMGP is pleased to announce that we have been awarded funding from Public Health England Capital Fund, recognising the value of our national network in contributing towards helping people overcome dependency on drugs and alcohol. As distribution of the funding is via local authorities, we are grateful to our partners Telford & Wrekin Public Health for their support in applying for the funding.

http://www.telford.gov.uk/info/20087/healthy_telford/442/public_health

**SMMGP and National Substance Misuse Non-Medical Prescribing Forum in new partnership**

SMMGP announces with pleasure that the National Substance Misuse Non-Medical Prescribing Forum has formalised links with us in a new partnership to pursue our stated aims to uphold standards of quality as a hallmark of good clinical practice in the field of drug and alcohol treatment.

We are therefore delighted to welcome the 460 members of NMP prescribing nurses and pharmacists into SMMGP, taking our overall joint membership to 8290.

The overarching aim of both our organisations is to ensure the provision of quality, evidence-based treatment for the people in our care by providing education and training, peer support and resources to colleagues working in the field and to engage with key stakeholders, including those who are in treatment.

Whilst maintaining our separate work streams, we look forward to working much more effectively and more closely with our nurse and pharmacist colleagues in the NMP Forum this year and into the future.

For more information, see http://www.smmgp.org.uk/html/news.php#Latest

## Post-it from Practice

### Return of the "Post Code Lottery" by Steve Brinksman

My practice has long had a reputation in Birmingham for working with people who use drugs and alcohol, and who are much more complex than those seen in most shared care practices. We were recently approached by the newly commissioned service to see if we would treat a man whom - for a variety of reasons - wasn't engaging with the main drug service. This has happened before and no doubt will again; as whilst a commissioned service is designed to deliver a good level of service to the majority of its clients, by virtue of commissioning arrangements it has to work within defined parameters.

So what happens when a client falls out with a service, or a service falls out with a client! It is a fact of life that we don't see eye to eye with everyone and sometimes irreconcilable differences develop, in my experience within drug and alcohol treatment this is frequently due to intransigence in both parties. However the service user can't fall back on or blame "procedures", "staff shortages" or "we aren't commissioned to do that" statements!

Previously when drug and alcohol treatment was part of health services, a service user would usually be placed in an alternative treatment system bearing in mind that access to NHS treatments should be fair, equitable and available to all. However since Public Health has moved into the realm of local government this seems to have changed. All councils will commission drug and alcohol services but I suspect they are less willing to fund the “square pegs” that may need to be sent to a different service. I have come across a number of clients now who simply fall through the cracks and due to a breakdown in the relationship with the “only show in town” are outside of treatment and despite wanting help, they can no longer access it.

We are fortunate in Birmingham to have a number of highly skilled GP practices as well as the central service for drug and alcohol treatment, so it is usually possible to accommodate most clients who have a problem with one provider, in an alternative service - albeit that a client may need to embrace change within themselves too for the arrangement to work.

I worry about what may happen elsewhere in the country if this diversity isn’t available, how many people are excluded from their local treatment provider [for whatever reason] and simply not able to find an alternative? And what should we do about it?